Response to Draft 1115 Waiver Application
By Health Care Council of Illinois (HCCI)
January 21, 2014

HCCI's member facilities represent the majority of Medicaid services delivered in Illinois nursing homes. We have a long history of supporting the expansion of home and community-based services, and we are an active partner with this Administration in reform measures, reimbursement challenges and regulatory necessities.

Our advocacy is to provide quality healthcare support and services to our residents, based on their medical and psycho-social needs. The Draft 1115 Waiver Application seems to ignore our partnership, as well as the vital role nursing homes contribute in the Illinois health care continuum. That said, there are several overall issues we would like to address, including:

1. The most troubling aspect of this waiver application comes in a single sentence on page 49. If this waiver is approved, Illinois will have the power to restrict "consumer choice" and steer our most fragile, vulnerable citizens to managed care. Freedom of choice a is basic right guaranteed by the Bill of Rights. We simply can't believe that this Administration would anticipate taking this most basic right from the elderly citizens in Illinois.

2. The drafters of this document argue the current "fee for service" system is unsustainable. Two years ago we went through a painful process to get Medicaid back on track. The Department of Healthcare and Family Services (HFS) projected a $1.7 billion dollar budget hole. This resulted in a massive project to revamp the program and make service cuts. All providers were expected to take their fair share in cuts. Reimbursement for optional services for nursing home residents was eliminated. On page 7, the document indicates that optional services are being restored as part of this waiver process. However, we can find no mention of dental, vision and podiatry services being restored for nursing home residents. Many of us have engaged in a number of activities to stabilize and add predictability to the Medicaid system, yet the drafters still argue the current system is "unsustainable". There is a huge disconnect here.

3. The draft waiver application does not contain enough detail for us to determine, in many cases, the type of nursing home resident that will be impacted. Are you talking about moving 94-year-old grandmothers to the community when the facility is the only home they have known for years? There are references to moving "a large number" of nursing homes residents. What does this mean? Where will they go and with what supports? We need to take a steep back and build a program.

4. HCCI learned the Administration plans to "outsource" the program development and implementation of this waiver project to an outside entity. This is a troubling trend that began with the Medicaid Managed Care program. The State seems to be disengaging responsibility for oversight of State-sponsored programs administered with taxpayer dollars. The State should maintain this responsibility.

5. The draft waiver application is silent about how the State plans to ensure quality services are delivered across the continuum of long term care. Program oversight is an important

component of building an effective program. Patient safety mechanisms are missing. There is no component to ensure the elderly people who move back to their own home will have the services needed to avoid self-neglect, and get enough supports to maintain quality of life and social activities.

6. There are two major stakeholders not mentioned in the draft application. The first is the Health Facilities Services and Review Board. This group will approve bed conversions, closures, facility upgrades. They should be engaged early in the process. The banking community is the second group. They must also be engaged in the process to ensure facilities are able to participate within their strict guidelines.

7. The draft application argues all services should be under a "single authority" resulting in "broad flexibility to manage the programs more efficiently and to align and coordinate programs where possible". Another section refers to maintaining "substantial flexibility" in program execution. One of the hallmarks of our current program is the inherent checks and balances. We believe caution should be used in consolidating all authority under one roof. The creation of "super agencies" has not worked in the past in Illinois.

Comments Specific to Nursing Home Programs:

8. A facility's ability to participate in any of the home and community-based activities is not anticipated. Many facilities already participate in these programs, such as respite programs and meals for the community. The 1115 waiver application should be expanded to include waivers for nursing homes to participate in delivering home and community-based services. We have long argued that nursing homes are community service organizations. This waiver provides the opportunity to recognize the vital role a nursing home plays in the service delivery system in a community, as well as expand that role. Facilities should be allowed to participate and "community health workers". The programs on page 52 should be extended to nursing homes. It will take a waiver to do this so it should be included in this proposal.

9. Can nursing homes be afforded the other programs of assistance anticipated for other provider groups? Nursing homes are a vital part of the safety net. In many counties, nursing homes are the only medical entity. Nursing homes in Chicago serve primarily Medicaid clients. Are nursing home staff members eligible for workforce development assistance or student loan forgiveness? Nursing schools and nurse aid training programs don't seem to be included in the educational component.

10. The waiver document creates "health homes" for the SMI population. On page 38 there is a reference to "moving SMI from institutions to the community". On page 39, it states that there will be "an effort to transition a large number of individuals from nursing homes to more community integrated settings, such as SMHRFs. When the SMHRF program was established, it was not anticipated that their purpose would be to replace a nursing facility's ability to care for SMI individuals with co-morbidities. In fact, the SMHRF Act specifically prohibits this. HCCI

presented a proposal to the Administration regarding how the SMHRF program and the facility-based SMI programs can work in tandem to serve this population.

11. Nursing home conversions, closure and diversion projects are all mentioned in the waiver. Some program details related to conversion and closures are included. Specifically, the criteria for closure or conversion projects are included. However, consideration for the individual receiving services or the impact of closure or conversion on the community doesn't seem to be considered until the last two criteria. We would like to work with the Administration to amend these criteria.

    Conversion programs have been proposed several times and never implemented. Will this happen again? Will funding be sufficient to make the program work? A formula for compensation to facilities is included. HFS holds all of the approval authority. We ask the detail be set aside in the application process and left for development later around a common table of stakeholders.

    Additional waivers will be needed to allow nursing homes to convert to other program delivery systems. This waiver application should include those necessary adjustments to make conversions permissive.

12. The concept of expanding home and community-based services to include providing for the "complex health and behavioral health needs" of our citizens is a theme that is pervasive throughout the document.

    It has generally been acknowledged nursing homes would continue to provide for complex medical needs, whereas lighter care could be provided in the community. The drafters of this document seem to have a different vision that does not reflect our current role. For example, we are in the process of completing a three- year project to convert Medicaid reimbursement to the RUGs system that reflects higher payments for the care of medically complex individuals. Managed care will soon be required for the majority of our residents. It is unclear to us how the 1115 Waiver project will impact both of these initiatives.

13. On page 49, it indicates that a waiver is being sought on the premise of retroactive eligibility. Eligibility determination for long term care residents is currently a mess. The amount of time it takes to get approval is growing into a months-long wait, and we've heard of some passing the year mark. In the meantime, facilities have to carry the cost of caring for those residents, providing shelter, food and medical services. The long delays in eligibility should be resolved immediately, and this certainly should be done before any waiver on retroactive approval is executed.

Closing:

We appreciate the opportunity to submit these comments. Questions can be directed to HCCI by calling (217)544-4224 or by emailing Mary Button at mbutton@hccil.org.